MONTANA BOARD OF MEDICAL EXAMINERS

PO Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 FAX (406) 841-2305
E-MAIL dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

PHYSICIAN ASSISTANT IS NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE AND SUPERVISION AGREEMENT ON FILE WITH THE BOARD.

(Please allow 30 days to process application from the date that the Board has a complete routine application)

LICENSING REQUIREMENTS:

- Must be a graduate of a physician assistant training program accredited by the accreditation review commission on education for the physician assistant or, if accreditation was granted before 2001, accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.
- Must have successfully passed an examination administered by the National Commission on the Certification of Physician Assistants
- Hold a current certificate from the National Commission on the Certification of Physician Assistants.
- Must be of good moral character.

FEES: $195.00 (Non-refundable) application fee includes the initial supervision agreement.
Make payable to: Montana Board of Medical Examiners

DOCUMENTS: The following documentation must be submitted to the Board office in order to complete your license application.

A Current National Practitioner Data Bank (NPDB) self-query (Letter Unopened)
A Current DEA Query form (Form enclosed)
Original State Licensing Verifications (Form enclosed)

NOTE: All Documents not in English must be accompanied by certified translations.

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

- **National Practitioner Data Bank (NPDB) self-query:** This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt, please forward them to the Board office. This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet.
- **DEA Query Form:** This form must be sent directly to the address indicated on the form. The results will come directly to the Board office. There is no fee required.
- **State Licensing Verification Form:** This form must be sent to all state boards or agencies in which you hold or ever held any license to practice in any profession. The completed verification, with original signature and seal, must be returned directly to the Montana State Board of Medical Examiners directly from that licensing agency.

APPLICATION PROCEDURES:

- When the application is complete, it will be processed and considered by Board staff for permanent licensure.
- If the application is considered non-routine there may be a delay in the processing of the application. The applicant may be notified to submit additional information as required or may be required to appear before the Board for a personal interview for consideration of the application during a regularly scheduled Board meeting. The Board meets six times per year every other month beginning in the month of January.
- All verifications of licensure must be sent directly to the Board office from each state licensing board in which the applicant is currently or has ever held a license. Please make copies of the attached verification request form as needed. Some states charge a fee for verifications. Contact each state board prior to sending the request to get specific information about requesting license verification.
- Keep the Board office informed at all times of any address changes or changes in license status, complaints or proposed disciplinary action. This is essential for timely processing of your application and subsequent licensure.

PROCESSING PROCEDURES:

- Once a completed routine application is received it may take up to 30 days to process.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- Please be sure the three individual character references you listed on your application complete the reference questionnaires form and return the form directly to the Board office as soon as possible in order to complete your application.
- The Board of Medical Examiners will verify your current NCCPA certification and examination through NCCPA online services. You will be notified if there are any irregularities with the verification.

For information with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 841-2361 or 841-2364 or email the board at dlibsdmed@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR PHYSICIAN ASSISTANTS ON OUR WEBSITE: www.medicalboard.mt.gov

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PLEASE TYPE OR PRINT IN INK.
(Please allow 30 days for processing from the date that the Board has a completed application)

Application for Licensure as: Physician Assistant

1. FULL NAME: _____
   Last First Middle

2. OTHER NAME (S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip

5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____

6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State

9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)

10. Have you ever previously applied for a license to practice in Montana? If yes, give date and results. ☐ Yes ☐ No

11. Have you ever been denied licensure or the opportunity to take a professional licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No

12. Have you ever withdrawn an application for a physician assistant license? If yes, please give the state and reason for withdrawal. ☐ Yes ☐ No

13. List all physician assistant and other professional licenses, which you hold or **ever** have held. Verification for each license must be sent directly to Montana from each state board.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplemental Sheet.

14. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No

15. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

16. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No

17. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

18. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No

19. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No

20. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No

21. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

22. Do you have any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

23. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

24. **PROFESSIONAL EDUCATION**:

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of Physician Assistant School or Program	City and State/Province/Territory	Dates Attended	Degree Earned or Completion Date

Residency Program (If applicable)	City and State/Province/Territory	Dates Attended	Diploma Received
			☐ Yes ☐No
			☐ Yes ☐No

25. **PRACTICE HISTORY:** List **all** activities after physician assistant school (other than those already set forth above) in Chronological order, up to and including the present. Specify nature of activity; for example, private practice, and hospital practice, vacation, school, private employment, etc. (Indicate specific month and year for each activity)

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

26. **PROFESSIONAL & CHARACTER REFERENCES**
Please type or print names and addresses of two physician references and additional reference that have known or associated with you for at least one year.

Name:
Address:
Telephone Number:

Name:
Address:
Telephone Number:

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Dated

Subscribed and sworn to before me this _____ day of _____, _____at

_____.
City/State

_____
Signature of Notary Public

SEAL

_____
Notary Public Printed Name

_____
For the State of

My commission expires _____, _____.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN ASSISTANT. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a license to practice as a physician assistant in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____

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TO THE APPLICANT

Please complete the identifying information and submit to:

DEA SALT LAKE CITY DO
DIVERSION GROUP
ATTN: CHAR MESSICK, R T
348 E S TEMPLE
SALT LAKE CITY, UT 84111-1202

Date: _____

To Whom It May Concern:

I am applying for a license to practice medicine in the State of Montana. Please indicate on the lower portion of this form if there is any derogatory information on file against me. I hereby specifically authorize the release of any and all information concerning me, and agree to hold the DEA harmless from any liability for the disclosure of such information. Please send this form directly to the Montana Board of Medical Examiners. Thank you for your assistance.

Name: _____

Date of Birth: _____DEA Registration Number: _____

Address where DEA Number is registered:_____

_____

_____ _____
Legal Signature of Applicant Please Print Name

DEA RESPONSE:

MONTANA BOARD OF MEDICAL EXAMINERS
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VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each character reference you have listed in your application (page 5).

_____ _____
Legal Signature of Applicant Date

(Please Type or Print):
Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Medical Examiners. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does this applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes," please explain: _____

Do you consider this applicant worthy of approval to practice as a licensed physician assistant in Montana? ____

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed)

_____ _____
Signature of Reference Date

Physician Assistant FAQ and Answers

1. What are the requirements for a physician assistant to be licensed in Montana?

    a. Good Moral Character
    b. Is a graduate of a physician assistant training program accredited by the accreditation review commission on education for the physician assistant or, if accreditation was granted before 2001, accredited by American medical association's committee on allied health education and accreditation or the commission on accreditation of allied health education programs.
    c. Has passed an examination administered by the National Commission on Certification of a Physician Assistants, Inc., (NCCPA)
    d. Holds a current certificate from NCCPA

2. What are the qualifications for a supervising physician?

    Must be a physician (Medical Doctor or Doctor of Osteopathy) who possesses a current, active license to practice medicine in Montana; exercises supervision over the physician assistant in accordance with statute and rules adopted by the Board; retains professional and legal responsibility for the care and treatment of patients by the physician assistant; and who agrees to a supervision agreement and a duties and delegation agreement. Refer to 37-20-101 and 37-20-401(4), MCA.

3. May a physician assistant practice once they receive an <u>active license</u> in Montana?

    No, in accordance with Board statutes 37-20-101, 37-20-104, 37-20-301 and 37-20-401, MCA, in order to practice as a physician assistant in the State of Montana the PA must possess an active PA Montana license and have a current supervision agreement on file with the Board. In addition effective October 1, 2005 with a 1 year grace period to get every PA and supervising physician in compliance with state law, the PA and supervising physician must have a duties and delegation agreement signed and on file in their possession available upon request by any other person, facility and/or the Board.

4. What is a physician assistant's scope of practice according to Montana Law?

    Under 37-20-403(3), MCA, the physician assistant may diagnose, examine, and treat human conditions, ailments, diseases, injuries, or infirmities, either physical or mental, by any means, method, device, or instrumentality authorized by the supervising physician. The authorization will be delegated by the supervising physician, in writing through the duties and delegation agreement kept current and on file by the supervision physician and physician assistant.

5. What is the prescribing and dispensing authority for a physician assistant?

    A physician assistant may prescribe, dispense, and administer drugs to the extent authorized by the supervising physician. All dispensing activities allowed by Montana law must comply with 37-2-104, MCA and with the packaging and labeling guidelines developed by the board of pharmacy under Title 37, chapter 7.

6. What is the maximum period a physician assistant is authorized to prescribe, dispense or administered of schedule II drugs listed in 50-32-224, MCA?

    34 days – in accordance with 37-20-404 MCA which has been effective since October 1, 1995

7. Where do you find regulations for prescribing in Montana?

    The Montana Board of Pharmacy laws Title 37, chapter 7 and Title 50 and Administrative rules under Title 24, chapter 174.

8. What are the potential consequences should a physician assistant violate his or her prescribing authority?

    a. Termination or restriction of Prescribing Authority by DEA or the Board
    b. Possible disciplinary action instituted against the Physician Assistant's license
    c. Possible disciplinary action instituted against the supervising physician's license

9. Under what circumstances does a revision to the "supervision agreement" have to be submitted to the board for approval?

    None, only New Supervision Agreements are submitted to the Board for approval. However, changes in alternate physicians (coverage when your supervising physician is unavailable) or changes to the Duties and Delegation Agreement are made, then the changes must be maintained on file by the both the supervising physician and physician assistant. The Duties and Delegation agreement must be made available when requested from the board or any other individual, such as hospital, administrators, other healthcare provider and/or patient etc.

10. Under what circumstances is it appropriate to submit a new supervision agreement?

    Prior to the PA beginning practice in a new working relationship with a supervising physician.

11. May a Physician Assistant practice without a supervision agreement ?

    No, under 37-20-104,MCA, Unlicensed Practice (2) prior to being issued a license and submitting a supervision agreement to the board, a physician assistant may not practice as a physician assistant in this state, even under the supervision of a licensed physician.

12. May a Physician Assistant practice without a duties and delegation agreement?

    No, under 37-20-301, MCA, (2) a supervising physician and the supervised PA shall execute a duties and delegation agreement constituting a contract that defines the physician assistant's professional relationship with the supervising and the limitations on the physician assistant's practice under supervision of the supervising physician . The agreement must be kept current, by amendment or substitution, to reflect changes in the duties of each party occurring over time. The board may by rule specify other requirements for the agreement.

    A physician assistant licensed by the board before October 1st 2005 shall execute a duties and delegation agreement with supervising physician by October 1st, 2006. (This is a grace period of 1 year to enact the new legislation)

13. If a physician assistant's only supervising physician is not available, whose obligation is it to ensure that supervision is in place?

    Both the supervising physician and physician assistant are obligated to ensure that there is active and continuous supervision, but do not require onsite, direct supervision or the physical presence of the physician, as long as there is a means of communication available between the supervising physician and the PA. However, in the event that communication is not available while the PA is practicing, the supervising physician must arrange for a back up physician to assist the PA as needed. The PA must be able to contact the physician designated as the supervising or covering in the absence of the supervising physician. This does not relieve the supervising physician's professional and legal responsibilities under 37-20-301,(1)(b) MCA.

14. Does a back up physician who is covering in the absence of the supervising physician need to be approved by the Board?

    No the Board will not be requiring back up physicians to be approved by board, or be notified of a change in any back up physician. However, the duties and delegation agreement between the physician and PA should describe the setting and continuous supervision method to utilize in their practice. (For example: On site, electronic, written instructions and/or protocols, back up supervising physician available or all of the above)

15. If you become aware of another healthcare provider that may be incompetent or committing unprofessional conduct, including chemical dependency or drug diversion, what should you do?

    a. If you are a physician, you are obligated to report acts of unprofessional conduct or incompetence as defined by 37-1-316, MCA, and/or board rules 24.156.625 for physician and 24.156.1625 for physician assistants.
    b. Healthcare providers licensed by the boards are required to self report during the renewal period of their license.
    c. You may also contact the Board's impairment program to assist the healthcare provider in question with any physically or mental impairment by habitual intemperance or the excessive use of addictive drugs, alcohol or any other drug or substance or by mental or chronic physical illness. The program is Montana Professional Assistance Program, (406) 245-4300, Mike Ramirez or contact the board office for the information. Your referral to MPAP may be anonymous.
    d. Anyone may file a complaint or provide information to the Board office regarding unprofessional conduct or incompetence.

16. Can a physician assistant practice independently?

    No, the physician assistant has a dependent practice and must be under physician supervision. Under 37-20-101 and 37-20-403, MCA, the supervising physician is professionally and legally responsible for the all care and treatment of the physician assistant's patients.

17. What is the definition of Supervision Agreement?

    In accordance with 37-20-401(5), MCA means a written agreement between a supervising physician and a physician assistant providing for the supervision of the physician assistant. In accordance with Board rule "supervision" is defined as accepting responsibility for, and overseeing all care and treatment of the physician assistant by telephone, radio or in person as frequently as necessary considering the location, nature of practice and experience of the physician assistant.

Note: For further information regarding Physician Assistant Montana Regulations please visit our website at: www.medicalboard.mt.gov

Board: MEDICAL EXAMINERS

GENERAL INFORMATION FOR SUPERVISION AGREEMENTS

In order to practice as a Physician Assistant (PA) in Montana the PA must have on file with Board in accordance to MCA: 37-20-301, a supervision agreement. The following outlines general information for a supervision agreement for new applicants to the State of Montana, a new supervising physician and PA practice relationship or a change in supervising physician.

A. **Application Fee:** $75.00 for new Supervision Agreement without Physician Assistant License application; new Supervision Agreement with Physician Assistant License application is included in the $195 PA license application fee, no additional fee required.

B. **New PA Applicant to the State of Montana**: Requires a completed license application and completed supervision agreement application provided by the board with original signatures and fees in the office.

C. **New supervision agreement without license application:** Requires a completed supervision agreement application provided by the board with original signatures and fees in the office.

D. **Supervising Physician** is defined as a medical doctor or doctor of osteopathy licensed by the Board who agrees to a supervision agreement and duties and delegation agreement.

E. **Qualification of Supervising Physician:**
   a. possess a current, active Montana license
   b. exercises supervision over the physician assistant in accordance with the rules adopted by the Board
   c. retains professional and legal responsibility for the care and treatment of patients by the physician assistant

F. **Qualifications for Physician Assistant** must have a current active Montana PA license.

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PLEASE TYPE OR PRINT IN INK.
(Please allow 10 days for processing from the date that the Board has a completed application)

Application for Supervision Agreement:

PHYSICIAN ASSISTANT INFORMATION:

1. FULL NAME: _____
   Last First Middle
2. BUSINESS NAME _____
3. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
4. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____
5. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
6. SOCIAL SECURITY NUMBER : _____ LICENSE NUMBER : _____
7. DEA REG. # _____ START DATE: _____

SUPERVISING PHYSICIAN INFORMATION:

1. FULL NAME: _____
   Last First Middle
2. BUSINESS NAME _____
3. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
4. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____
5. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
6. SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____
7. DEA REG. # _____ START DATE: _____

Requirements for use of a Physician Assistant:

A physician, office, firm, state institution or professional service corporation may not employee or make use of the services of a physician assistant in the practice of medicine unless the physician assistant is supervised by a physician licensed in the State of Montana, possesses a current active Montana PA license and has completed and submitted this Supervision Agreement application form with fee to the Board.

Scope of Practice:

A physician assistant may diagnosis, examine and treat human conditions, ailments, diseases, injuries or infirmities either physical or mental by any means, method, device or instrumentalities authorized by the supervising physician. The above named supervising physician and physician assistant shall execute a duties and delegation agreement constituting a contract that defines the physician assistants professional relationship with the supervising physician and the limitations on the physician assistant's practice under the supervision of the supervising physician. The duties and delegation agreement must be kept current by amendment or substitution to reflect changes in the duties of each party occurring over time. ***(All physician assistant's licensed prior to October 1, 2005, shall execute a duties and delegation agreement with their supervising physician by October 1, 2006. Physician assistants licensed after October 1, 2005 must have a duties and delegation agreement on file prior to commencing practice.)***

Supervision:

A physician assistant is considered the agent of the supervising physician with regard to all duties delegated to the physician assistant. The supervising physician is professionally and legally responsible for the care and treatment of a patient by a physician assistant. The onsite or direct supervision of a physician assistant by the supervising physician is not required if the supervising physician has provided a means of communication between the supervising physician and the physician assistant or has provided an alternate means of supervision in the event of the supervising physician's absence.

Alternate means of supervision for periods of absence:

When the supervising physician is unavailable by means of communication the following alternate means will apply:

☐ The supervising physician will provide for a back up supervising physician(s) to supervise the above listed PA when the supervising physician is unavailable. A list of the back up supervising physician(s) must be on file with the duties and delegation agreement, kept current and available upon request by the Board. ***(Important Note: Having a back up supervising physician doesn't relieve the supervising physician listed in this agreement of the professional and legal responsibilities for the care and treatment of patients by the PA listed above.)***

OR

☐ The physician assistant will cease to practice when the supervising physician is unavailable.

Chart Review:

The Board of Medical Examiners has set the following for chart review:

A. Chart review must be conducted at a minimum on a monthly basis.
B. Chart review may not be less than 10 % under any circumstance.
C. For a licensed PA, with less that 1 year of full time practice experience from the date of initial licensure, for each new supervision agreement, chart review must be 100% for the first three (3) months of practice. Following the first (3) months of 100% chart review the supervising physician may reduced the chart to not less than 25% for next (3) months.
D. The supervising physician shall countersign all written entries chart reviewed and document any corrections, errors or guidance provided.
E. For PA's issued a probationary license, chart review must be 100% until termination of the probationary period by the Board.

AFFIDAVITS AND SIGNATURES

I hereby declare under penalty of perjury the information included in my supervision agreement application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question or request for information may lead to a denial of my application or grounds for subsequent disciplinary action imposed on my licensure. I further affirm that I have read and accepted the licensing statutes and pursuant to my profession, including supervision agreement and duties and delegation agreement, and hereby certify that I will abide by all statues and rules of the Board of Medical Examiners that pertain to my licensure. I acknowledge and understand that I may not practice medicine independently pursuant to 37-20-104(2) and 37-20-301, MCA.

Physician Assistant:

(Print Name) (Signature) (Date)

PRIMARY SUPERVISING PHYSICIAN AFFIRMATION

I affirm that I have read and understand the current Board of Medical Examiners statutes and rules, including those pertaining to physician assistant, supervision agreements and duties and delegation and my responsibilities as supervising physician. I acknowledge and agree pursuant to 37-20-101, 37-20-301, 37-20-403, MCA to exercise appropriate supervision over the above named PA in accordance with all statues and rules of the Board of Medical Examiners. I acknowledge and agree that I will retain professional and legal responsibility for the care and treatment of patients by the above named PA. I understand that duties and responsibilities may be delegated, or restrictions imposed, at my discretion, including additional limitations on prescribing and dispensing of drugs above those granted by the Board, pursuant to 37-20-404, MCA, and will be reflected in the duties and delegation agreement.

Supervising Physician:

(Printed name) (Signature) (Date)